



SAFETY TRAINING PROGRAM FEEDBACK

Name (Optional): _____

Course Title: _____

Instructor: _____ **Date:** _____

1. How would you rate the instructor's knowledge of the subject presented? (5 being best)

O1 O2 O3 O4 O5

2. Did you clearly understand the training information presented? (5 being clearly understood)

O1 O2 O3 O4 O5

3. Will the information help you do your job more safely?

Yes_____ No_____

4. What improvements would increase the value of this training for you?

(Example: additional handouts, instructor, training aids, etc)

5. Were questions answered to your satisfaction?

Yes_____ No_____

6. Would you recommend to your supervisor that others attend this training?

Yes_____ No_____

7. Do you have any comments or suggestions?

Please return to the Safety Department, mailstop 5-1.